

SENIOR CITIZENS LAW OFFICE

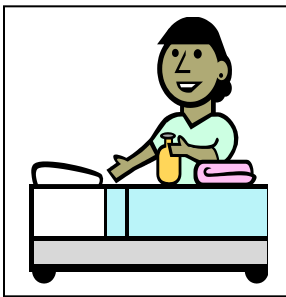
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INSTITUTIONAL MEDICAID FACT SHEET

1. Does the state of New Mexico have a Medicaid program for people in nursing homes?

Yes. The New Mexico Human Services Department (HSD) administers a Medicaid program for individuals who are in a medical institution for at least 30 days when nursing home care is determined to be medically necessary.

2. What is the definition of "Medical Institution" for this program?



"Medical Institution" means a state licensed Medicaid qualified nursing home; an acute care hospital; an in-state, inpatient rehabilitation center; an Intermediate Care Facility for the Mentally Retarded; or a swing bed (long term care bed in a rural hospital). Inpatient psychiatric hospitals, out of state rehabilitation centers, and boarding and shelter homes ("assisted living") do not fall under the definition of Medical Institution. A review agency must determine that the patient meets the level of care required for eligibility in a nursing home or an Intermediate Care Facility for the Mentally Retarded. The nursing home can help with this.

3. Who runs the nursing home Medicaid program?

As of July 1, 2008, New Mexico is contracting with two Managed Care Organizations to operate the nursing home Medicaid and certain other Medicaid programs through the CLTS (Coordinated Long-Term Services) program. If you are approved for Medicaid, you will have to select between the two MCOs, AMERIGROUP and Evercare. The other programs administered through CLTS include: Disabled & Elderly Waiver, PCO, Mi Via and dual-eligibles (Medicare & Medicaid).

4. How much income can a person receive and be eligible for institutional Medicaid?

Effective January 1, 2009, in order to be eligible, the individual's total countable monthly income must be less than \$2,022. The state disregards the first \$20 of most types of income, so in most instances, the individual can have up to **\$2,042** in *gross* monthly income.

If the person in the Medical Institution is married, community property principles may be used to determine the individual's income if it is advantageous to the applicant. This means that the institutionalized individual's income may be calculated by adding up both spouses' income and dividing in half. For instance, if the husband in the nursing home has \$2,000 in monthly income, and the wife at home has zero income, the countable income for the

husband is \$1,000, and he meets the income test for Medicaid coverage. If the applicant spouse's own income is less than **\$2,042**, (s)he is clearly income eligible and the other spouse's income will not be considered.

Certain types of income, such as certain types of veteran's benefits (allowances for aid and assistance [A&A] and unusual medical expenses [UME]) and certain types of payments made to Indians, are not counted in determining eligibility. Sometimes individuals with incomes higher than **\$2,042** may be eligible, especially those with Income Diversion (*income only*) Trusts.

5. If a married person is eligible for institutionalized Medicaid benefits, will all his/her income be used for his/her care?

At a minimum, the community spouse is entitled to a total combined monthly income of \$1,822. For instance, if the husband in the nursing home has a monthly income of \$1,800 and his wife at home receives \$200 each month, then she is entitled to at least \$1,622 each month from her husband's income. The wife at home may be entitled to more depending on her necessary living expenses (this is the monthly excess shelter deduction allowable to the community spouse where allowable shelter expenses exceed \$547). The maximum shelter deduction allowed is \$917, so that the total monthly income cannot exceed **\$2,739** for 2009 unless a court awards a greater amount to the community spouse.

6. Must the community spouse contribute his/her income to the institutionalized spouse?

No. The community spouse may keep all his/her income and is not required to contribute to the cost of the institutionalized spouse's institutional care once (s)he is receiving Medicaid regardless of the amount of the community spouse's income.

7. How much can the institutional care applicant have in resources and still be eligible for Medicaid?

The resource test is currently **\$2,000** for institutional Medicaid applicants but an additional **\$1,500** may also be set aside for burial expenses depending on the value of any life insurance owned by the applicant or other types of burial trusts for the applicant's benefit.

Resources include cash on hand, savings, certificates of deposit, bonds, stocks, real property, and life insurance with a cash-in value. Some personal property, such as a car and home furnishings, are not counted as resources. Special rules may apply to certain assets, such as annuities. If a person intends to return to their home, the home is usually not counted as a resource. If, however, an individual has greater than \$750,000 in equity in their home, they will not qualify for Medicaid unless a spouse or a dependent or disabled child resides in the home.

If the institutionalized Medicaid applicant is married, the community spouse is entitled to retain one-half of the couple's combined countable resources (up to a maximum of \$109,560) or \$31,290 in resources, whichever is greater. Any resources that the community spouse is not entitled to keep are counted as resources belonging to the institutionalized spouse for purposes of determining Medicaid eligibility.

To determine the total amount of the couple's resources, the Human Services Department will perform an "assessment." The applicant or spouse provides all necessary financial information and the caseworker lets the couple know how much, if any, must be spent on the

couple=s joint debts and/or institutional care before eligibility can begin, and how much can be protected for the spouse at home. A court may order that a greater amount of resources be protected for the community spouse. (Private attorneys who specialize in elder law should be consulted about Medicaid planning options.)

8. **Is the home counted as a resource to the institutionalized Medicaid applicant?**

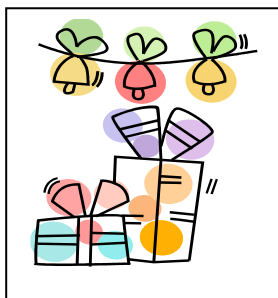


The home is not counted as a resource in several instances. First, for single or widowed individuals entering a nursing home for long-term care, the value of the home is not counted if the individual *expresses an intent to return to their home*. Next, the home is not counted as a resource if it is transferred to a spouse or a dependent or disabled child; a brother or sister who has an equity interest in the home and who resided in the home for one year prior to institutionalization; or to a child who is not a dependent, but who had resided with and cared for the institutional Medicaid applicant for two years prior to the applicant's institutionalization.

As noted previously, however, an individual with greater than \$758,000 in equity in their home will not qualify for Medicaid, regardless of any expressed intent to return home, unless a spouse or a dependant or disabled child resides in the home.

9. **Can an individual transfer or gift their resources and be eligible for Medicaid coverage?**

Any transfers or gifts of property, other than those specifically allowed between spouses and dependent or disabled children, may cause ineligibility for Medicaid nursing home care for certain periods of time. Transfers or gifts are anything of value given away for the purpose of qualifying for Medicaid. They include selling property for less than the property's fair market value, removing someone's name from or adding someone's name to property or liquid assets such as bank accounts or other investments, or placing resources or income in trusts with limited availability.



If a transfer was made before February 8, 2006, it will be evaluated if it occurred within 36 months (3 years) of the date of application for Institutional Care Medicaid. Transfers occurring on or after February 8, 2006 will be evaluated if they occurred within 60 months (5 years) of the date of application for Institutional Care Medicaid. Ineligibility is calculated by dividing the value of the transferred asset by the average monthly nursing home cost. For 2010, the official average monthly nursing home cost is \$5,269.

Since any transfer or gift not authorized under the Medicaid rules can result in a period of ineligibility, it is important that individuals who are considering a gift or transfer first speak with an attorney knowledgeable in Institutional Medicaid rules.

10. **Are there any exceptions to these rules that might allow an individual otherwise disqualified from receiving Medicaid to nonetheless obtain it?**

Yes. Although a person is usually disqualified from receiving Medicaid for a certain period of time when they make an unauthorized gift or transfer, the state Medicaid office may waive enforcement of this rule if the individual petitions for a "Hardship Waiver" based on the fact

that the individual's health or life would otherwise be endangered or the individual would otherwise be deprived of food, clothing, shelter, or other necessities of life. Additionally, the state Medicaid office may waive enforcement of the rule requiring disqualification of individuals with home equity exceeding \$500,000 if the individual can prove that they will suffer 'demonstrated hardship' if denied Medicaid.

11. Can an individual put their home or other resources in a trust and be eligible for Medicaid?

Federal law requires in most instances that the state count as income, income paid from a trust; and as resources, the trust corpus. There are exceptions for persons who are "disabled" under Social Security guidelines. In addition, individuals over the age of 65 who transfer assets to a trust may also be penalized for the transfer and denied Medicaid for a period of time. An attorney knowledgeable in Medicaid trust law should be consulted prior to establishing a trust for an elderly or disabled person.

12. After an individual becomes eligible for Medicaid, can his/her income be used to pay off old bills?

After eligibility is established, most of a single individual's income must be paid toward the cost of nursing home care. Sixty-three dollars (\$63) per month is allowed for personal needs, and additional amounts may be used for non-covered medical expenses, such as payment of the Medicare Part B premium, old medical bills, and medical services that are not a benefit of the New Mexico Medicaid program (such as chiropractic services, acupuncture, etc.).

13. How does a person apply for institutional Medicaid?

Applications for institutional Medicaid are available at the local county office of the Human Services Department and from many nursing homes. The applicant must verify all factors of eligibility with appropriate documentation. Bring proof of the applicant's Social Security number, citizenship or alien status, residency, resources, income, spouse's income, expenses to maintain the home if married, and transfers within the past 60 months. Begin to gather all pertinent information as soon as possible as this will expedite the application process. Caseworkers can help applicants find necessary documentation.

If you wish additional advice on Institutional Medicaid issues, you may contact the following agencies for general information and referrals:

- Senior Citizens' Law Office
 - 265-2300 (Over 60; Bernalillo, Sandoval, Torrance and Valencia County Residents Only)
- Lawyer Referral for the Elderly Program (Over 55; statewide)
 - 797-6005 (Albuquerque)
 - 1-800-876-6657 (New Mexico Residents outside of Bernalillo County)
- N.M. Aging & Longterm Services Division
 - 1-800-432-2080
 - 1-505-476-4846